FINAL STATEMENT OF REASONS

California Code of Regulations
Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 11. Medi-Cal Specialty Mental Health Services

Subchapter 3. Specialty Mental Health Services Other Than Psychiatric Inpatient Hospital Services.
Article 2. Provision of Services.
Section 1830.215. MHP Payment Authorization

And

Subchapter 4. Federal Financial Participation.
Article 1. General.
Section 1840.112. MHP Claims Certification and Program Integrity.

Description of the Public Problem, Administrative Requirements, and Other Conditions and Circumstances these Regulations Are Intended to Address:

Summary of Action

This regulatory proposal amends Section 1830.215 to establish specific Medi-Cal mental health plan (MHP) payment authorization requirements for certain Medi-Cal specialty mental health services and adopts Section 1840.112 to establish specific MHP claims certification and program integrity requirements for all Medi-Cal specialty mental health services. It is the intent of the Department of Mental Health (DMH) to require MHPs to verify that Medi-Cal specialty mental health services have been provided in accordance with regulations and standards through the MHPs' payment authorization systems and the MHPs' certification of Medi-Cal claims.

Explanation of Authority

The Department of Health Services (DHS) is the single state agency under federal medicaid law with the responsibility and authority for administering the Medi-Cal program, including the supervision and oversight of other entities providing Medi-Cal services. Federal law at 42 United States Code (USC) 1396a(a)(11) requires that a State medicaid plan must "provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services . . . looking toward maximum utilization of such services in the provision of medical assistance under the plan." This federal law conveys authority for the interagency agreement between DHS, the single state medicaid agency, and DMH whereby DMH agrees to provide administration and oversight of MHP contracts and the provision of medically necessary specialty mental health services to Medi-Cal beneficiaries in accordance with California's state medicaid plan and approved federal waivers (see Reference Document D).

As set forth in the interagency agreement between DHS and DMH and described in California's Social Security Act Section 1915(b) Medi-Cal managed mental health care waiver programs approved by the federal Centers for Medicare and Medicaid Services, DMH is responsible for the development and implementation of the Medi-Cal managed mental health care program, subject to DHS review, approval and administrative discretion, and to the extent authorized by and consistent with federal and state laws and regulations (42 USC 1396a(a)(5), (11); 42 Code of Federal Regulations [CFR] 431.10; and Welfare and Institutions Code [WIC] 5775 et seq. and 14680 et seq). Under this program, DMH is required to contract with MHPs (as defined in Section 1810.226; currently all MHPs are counties), to provide Medi-Cal specialty mental health services.

Reasons for Action

Under the interagency agreement and federal waivers, the Director of DMH is authorized, subject to DHS review and approval, to adopt these emergency regulations to prevent and curtail fraud and abuse in the provision of Medi-Cal specialty mental health services, pursuant to WIC 14043 et seq. and 14043.75.

This regulatory proposal is necessary to prevent and curtail provider fraud and abuse, defined in WIC 14043.1, by imposing specific payment authorization and claims certification and program integrity requirements to ensure that claimed services are actually provided and that they are provided in accordance with sound fiscal, business and medical practices and professional standards, are not unnecessary or substandard, do not result in unnecessary costs to or reimbursement by the medicaid or Medi-Cal program and/or do not otherwise constitute fraud or abuse.

Former Section 1830.215 was adopted on an assumption that requirements and standards relating to medical necessity, quality assurance and utilization review of covered Medi-Cal specialty mental health services, including day treatment intensive, day rehabilitation, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services, were sufficiently clear for MHPs and providers to implement. However, DMH has now determined through program reviews and monitoring that some day treatment intensive and day rehabilitation services may not have been provided in a manner consistent with existing requirements related to service definitions (Sections 1810.212 and 1810.213), medical necessity (Sections 1830.205 and 1830.210), claiming for time (Section 1840.318) and staffing ratios (Sections 1840.350 and 1840.352). DMH has also determined that documentation of initial assessments, treatment plans, therapeutic behavioral interventions, and assessments of progress for EPSDT supplemental specialty mental health services may not have been adequate or complete.

In addition, as set forth in the June 20, 2002 United States Department of Justice press release (see Reference Document B), the State of California and the County of Los Angeles agreed to reimburse the federal government for allegedly ineligible claims for

Medi-Cal/medicaid services, including mental health services. In conjunction with these allegations and settlement, the federal government also conducted its own review. The intent of this regulation package is to prevent the problems with the delivery of Medi-Cal specialty mental health services identified in these federal and state reviews from recurring.

Based on the determinations described above and the need to prevent or avoid circumstances that might give rise to allegations of false claims, DMH determined that these potential problems with the delivery of Medi-Cal specialty mental health services must be addressed. Therefore, these regulations implement new MHP payment authorization standards for day treatment intensive, day rehabilitation and EPSDT supplemental specialty mental health services and implement new requirements for claims certification and, effective August 13, 2003, new program integrity requirements, for all Medi-Cal specialty mental health services, in conformance with federal medicaid managed care plan requirements.

The proposed regulatory action also implements, in part, WIC 5767, which was added by AB 442 (Chapter 1161, Statutes of 2002) effective September 30, 2002, regarding the Medi-Cal EPSDT benefits.

In adopting these regulations, it is not DMH's intention to interfere in any way with the implementation of *Emily Q. et al. v. Bontá* (Case No. CV 98-4181 AHM, United States District Court, Central District of California). The *Emily Q* court order requires that identified Medi-Cal class members be assessed as to medical necessity for and have access to therapeutic behavioral services (TBS), which is the only service offered in the category of EPSDT supplemental specialty mental health services (see Reference Document C). On the contrary, these regulations should ensure that Medi-Cal beneficiaries in the classes specified in the lawsuit, who are properly entitled to receive TBS, will, in fact, receive them.

Consultation with the California Mental Health Directors Association (CMHDA) and other Stakeholders

DMH consulted with CMHDA and other stakeholders regarding the need and the proposed method for the establishment of MHP payment authorization requirements for day treatment intensive and day rehabilitation services and EPSDT supplemental specialty mental health services (see Reference Document A). DMH determined the MHP payment authorization system to be a crucial managed care principle and tool, since effective utilization control is one of the most effective options available to managed care plans to provide medically necessary services while managing the cost of care. This position is supported by the new federal medicaid managed care regulations at 42 CFR 438.210.

Specific Necessity and Reasons for Amendment of Section 1830.215

Section 1830.215 previously allowed the MHPs to determine the services for which they would require MHP payment authorization, if any. In the amended Section 1830.215, new subsection (c) mandates MHPs to require payment authorization for day treatment intensive, day rehabilitation and EPSDT supplemental specialty mental health services. The MHP payment authorization requirements ensure that the services are appropriately authorized and meet medical necessity criteria. In addition, new subsection (c) is necessary to implement requirements of the new federal medicaid managed care regulations, including 42 CFR 438.210(a) and (b), which requires medicaid managed care plan contracts to incorporate coverage provisions, utilization controls, and payment authorization of services requirements.

New subsection (c) also implements requirements of WIC 14043 et seq. to prevent potential fraud and abuse in the provision of day treatment intensive, day rehabilitation and EPSDT supplemental specialty mental health services. As a result of the audits and reviews mentioned earlier, DMH determined that day treatment intensive, day rehabilitation and EPSDT supplemental specialty mental health services have been particularly vulnerable to inappropriate claiming. Requiring MHP payment authorization prevents potential fraud and abuse by requiring reviews of providers' determinations of medical necessity and request for services, including the type, amount and duration of requested services.

Subsection (c) implements, in part, WIC 5767, which requires DMH to strengthen and ensure statewide application of managed care principles, building on existing county systems, to manage the Medi-Cal EPSDT benefit while ensuring access to eligible Medi-Cal recipients. DMH determined the MHP payment authorization system to be a crucial managed care principle and tool, since effective utilization control is one of the most effective options available to managed care plans to provide medically necessary services while managing the cost of care. This position is supported by the new federal medicaid managed care regulations, which provide specific requirements for managed care plan authorization systems at 42 CFR 438.210. In addition, all MHPs have existing MHP payment authorization systems that address, at a minimum, psychiatric inpatient hospital services. Subsection (c) established DMH authority to establish MHP contract obligations for MHP payment authorization of day treatment intensive, day rehabilitation, and EPSDT supplemental specialty mental health services, all of which are important EPSDT benefits.

In addition, WIC 5777(c) provides that changes in an MHP's obligations must be accomplished through contract amendment, consistent with federal requirements for medicaid managed care programs to operate under contracts between the State and the managed care entity, which is the MHP in the Medi-Cal managed mental health care program. (See 42 CFR Part 438, commencing with Section 438.1.) This regulatory action establishes basic principles and minimum requirements. Based on these

minimum requirements, DMH will obtain specific amendments to MHP contracts, consistent with federal and state law, to ensure adequate compliance by each MHP. This regulatory action makes specific DMH's authority to obtain MHP contract amendments and requires MHPs to carry out specific utilization controls, through their contracts designed to prevent and reduce potential fraud and abuse, while assuring access to appropriate services.

Former subsection (c) is relettered (d) as a non-substantive change.

Specific Necessity and Reasons for Adoption of Section 1840.112

New Section 1840.112 implements the requirements of WIC 14043 et seq. to prevent potential provider fraud and abuse by establishing MHP requirements for certification of claims and program integrity, including those established in the new federal medicaid managed care regulations. Compliance with these requirements is necessary before MHPs may receive reimbursement of federal funds.

Subsection (a) prevents potential provider fraud and abuse by making the MHPs' overall responsibility for certification of claims and program integrity clear to MHPs and their providers. With the exception of the obligations under 42 CFR 438.608, this subsection reflects current obligations of MHPs, not new policy or obligations. Significant state laws and federal regulations related to the certification of claims are included to ensure the MHPs and the public have a clear idea of the scope of the MHPs' responsibilities for certification of claims. This subsection also provides a context for the new requirements established by subsection (b).

Subsection (a) requires MHPs to comply with 42 CFR 438.604 and 438.606. 42 CFR 438.604 requires that managed care plans certify the accuracy, completeness and truthfulness of data and documents submitted to the State for the claiming of federal financial participation, including enrollment information, encounter data, and other information required by the State and contained in managed care plan contracts, proposals, and related documents. 42 CFR 438.606 specifies that this data must be certified by the managed care plan’s Chief Executive Officer, Chief Financial Officer, or an individual with delegated authority. DMH currently requires that MHPs' certification of claims for federal funds meet these requirements.

Subsection (a) requires that MHPs comply with the specific requirements of 42 CFR 438.608, pertaining to program integrity, by August 13, 2003. 42 CFR 438.608 requires that MHPs must: a) develop a mandatory compliance plan designed to guard against fraud and abuse; b) develop written policies, procedures, and standards of conduct that articulate the county’s commitment to comply with applicable federal and state standards; c) designate a compliance officer and compliance committee; d) conduct effective training and education for, and establish lines of communication between, the compliance officer and the organization's employees; e) enforce standards through well-publicized disciplinary guidelines; f) provide for internal monitoring and auditing; and g)

provide for prompt response to detected offenses and development of corrective action initiatives relating to the MHP contract. The designation of a compliance officer and the development of a compliance plan represent new costs to the MHPs. Funding for these new costs is included in the Fiscal Year 2003-04 Governor's Budget based on an implementation date of August 13, 2003. DMH has established the effective date of the new requirement to correspond with the funding.

Subsection (b)(1) requires certification that clinical assessments comply with MHP contract requirements because assessments form the basis for building a comprehensive clinical picture of the beneficiary and for determining whether and what services are needed. The assessment process is critical in ensuring appropriate care and preventing over-utilization, including unnecessary services.

Subsection (b)(2) requires certification that the MHP has verified the client's Medi-Cal eligibility because DMH has determined that this is a key factor of false claims. Claims should not be submitted or paid for clients ineligible for services.

Subsection (b)(3) requires certification that the MHP has verified that the services for which federal financial participation is being claimed were delivered to the beneficiary. Otherwise, the claim should not be submitted or paid.

Subsection (b)(4) requires certification that medical necessity has been established for the services being delivered because medical necessity criteria are the key factors in determining whether or not a service is eligible for Medi-Cal reimbursement through the MHP. Claims should not be submitted or paid for services that are ineligible for reimbursement to the MHPs.

Subsection (b)(5) requires certification of the development and maintenance of client plans, because client plans form the basis for the initial and ongoing delivery of specific services that address the beneficiary's clinical needs and treatment goals. In addition to assessments and medical necessity determinations, client plans are critical to ensure that the type, level, amount and duration of services are appropriate.

Subsection (b)(6) requires certification that MHP payment authorizations for day treatment intensive, day rehabilitation and EPSDT supplemental specialty mental health services were conducted in accordance with MHP contract requirements in order to ensure that claims are appropriate and conform with requirements contained in the MHP contracts.

Documents Provided in the Rulemaking File as Reference

A. Summary of comments regarding MHP payment authorization, stakeholder meetings of August 26, 2002 and October 11, 2002.

B. June 20, 2002 press release by the United States Department of Justice regarding settlement of claims brought by Gurubanda Singh Khalsa.

C. Judgment and Permanent Injunction, *Emily Q. et al. v. Bontá* (Case No. CV 98-4181 AHM, United States District Court, Central District of California)

Documents Relied Upon

D. DHS/DMH Interagency Agreement No. 02-25271 and Amendment 1